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Key words: Patient experience, emotional labour, qualitative methods

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Abstract

Objectives: This paper explores the content of letters of complaint by patients and carers about the behaviour, attitudes and communication of healthcare staff.

Background: The most common focus of patient complaints in the UK and other high-income countries is staff attitudes, behaviour and communication. There is a move to learn lessons from patient complaints which can be used to improve patient care and experience.

Methods: Fifty letters of complaint made by patients and carers relating to the behaviour, attitudes and communication of healthcare staff were analysed.

Results: Poor attitudes, behaviours and communication have significant negative impact on the emotional wellbeing of patients and carers. Many patients and carers have heightened sensitivities due to both health related stresses and also other factors. The health care role is expected to include compassion and kindness. The concept of emotional labour is useful in explaining the skills and effort required of staff in this often invisible and undervalued aspect of health care.

Conclusions: Given the increasing focus on patient experience, it is important that the importance of good staff attitudes, behaviours and communication is understood and that the emotional labour associated with this is recognised.

Key words: emotional labour, patient experience, qualitative methods

Summary Box What does this paper add?

- Important lessons can be learnt from analysing complaints to provide valuable insights into patients' and families' expectations and experiences of health care
- The public expects healthcare workers to have a high level of communication skills which can take account of situations where people, for reasons which may or may not be obvious, feel very stressed
- The concept of emotional labour, often seen as an invisible aspect of health care, may be useful in training healthcare staff to convey compassion and kindness and provide sensitive care to patients and their families

INTRODUCTION

The study reported in this paper originated in concerns within the study area about rising numbers of complaints from patients and their families relating to staff attitudes, behaviours and communication. In addition to investigating and responding to the individual complaints, it was decided that it would be useful to analyse a sample of those complaints which were at least partially upheld to gain general insights which could then be used to take steps to improve these aspects of health care.

From over 37 million contacts each year with NHS Scotland and associated contractors such as general practitioners, an average of just over 11,000 (1/3,500 contacts) complaints a year are made (Scottish Health Council 2009). The most commonly mentioned problems are communication issues (47%) and staff attitudes and behaviour (42%), followed by medical treatment (35%). Similar findings have been demonstrated in other healthcare systems in high income countries; for example, Taylor et al. (2002) reported that 32% of complaints about an Australian emergency department related to communication including poor staff attitudes and behaviour.

The health board where this study was undertaken provides comprehensive hospital, primary care and community health services to a population of approximately one million acting as both

commissioner and provider of these services, plus also providing secondary and tertiary referral services for other parts of Scotland. Scottish Health Boards therefore deal with complaints about the full range of acute and community health services. This is in contrast to some other parts of the UK where health services are commissioned by one organisation and provided by a range of different organisations and also many other developed countries with insurance based health care involving commissioners and a variety of health care providers

In the UK the need to learn from patient complaints and take actions to change services was highlighted by The Francis Inquiry (Francis 2010) into the failings in Mid Staffordshire hospitals and also in a report by the Kings Fund (Robert et al. 2011). Similar recommendations were made by an investigation into the handling of patient complaints by the Parliamentary and Health services Ombudsman (2013), the body who make final decisions on complaints that have not been resolved by the NHS in England, which is equivalent to the role of the Scottish Public Services Ombudsman in Scotland, where the study was undertaken. The Scottish Government's Healthcare Quality Strategy (Scottish Government 2010) and the National Institute for Clinical Excellence (NICE 2012) identify the importance of good communication, kindness and compassion in patient care.

AIMS

The aims of the study reported in this paper were:

1. To identify and explore the content of patient complaints relating to communication, attitudes and behaviour of health care staff.
2. To provide information and recommendations to underpin the development of interventions to improve the patient experience.

METHODS

Fifty consecutive letters of complaint to one Scottish health board during January – June 2011, relating to communication and/ or staff attitudes or behaviours, which met the inclusion criteria of the study, were downloaded from the electronic complaints handling system. The letters were anonymised by the complaints service before being handed to the researchers. Complaints were made by letters written by patients and family members, sometimes with the assistance of advocacy workers (for example, from voluntary agencies). Letters of complaint were eligible for inclusion if, following investigation, the complaint had been at least partially upheld and had been classified by the investigators as relating to communication or attitudes and behaviour of staff. Letters were excluded if they were: an incomplete record of complaint, incoherent, part of a long-running correspondence, or relating to complaints which were not at least partially upheld. The study only covered the content of the initial complaint and the viewpoint of the complainant. The researchers had no knowledge of which parts of the complaint had been upheld or the perspectives of the staff concerned.

The data were read initially by one author (RH) and then verified by another author (JH) and units of meaning were given codes, using NVivo to organise the data. Content analysis, described by Hsieh and Shannon (2005) as “a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns” (p 1278), was used to explore the data. As there is little previous research relating to the understanding of the reasons underlying the behaviours, attitudes and communication styles which generate complaints from patients and their carers, preconceived categories were not used and the researchers allowed new insights to emerge from the data inductively, as advocated by Kondracki and Wellman (2002).

The study was deemed to be service evaluation and did not require ethical approval.

FINDINGS

Table 1 details the clinical area and the post held by the member(s) of staff identified by the complainant.

The main themes identified from the letters were:

1. The identification of good aspects of care within the complaints scenario
2. Contextual factors affecting sensitivity to staff attitude, behaviour and communication
3. Failure to meet expected norms of communication in a formal encounter
4. Deliberate attempts to cause distress
5. The effect of poor experiences

These themes are presented in detail and then discussed with respect to pertinent literature.

Illustrative quotes are presented with the analysis and pseudonyms have been used throughout.

The identification of good aspects of care within the complaints scenario

Many descriptions of poor attitudes, behaviour and communication were set against clear depictions of good experiences of these factors from health care staff, both previously and also during the episode of care which instigated the complaint. This provides a valuable insight into what patients expect of the health care role. For example one complainant wrote:

"The consultant was kind, considerate and explained everything that would need to be done, carefully ensuring I understood the implications of the decisions I needed to make." (Watson)

Another complainant described a positive experience with midwives:

"She ensured my concerns were listened to and reassured me throughout my pregnancy. She took time to visit each bed, introduced herself, advised that she and another midwife were on during the night and that if we needed anything to buzz them." (Laidlaw)

All the descriptions of good attitudes and communication depicted a sense of being afforded time – to listen, reassure, explain and to be available to patients. They also created a feeling of being cared for and about and confirmed patients' and families' expectations for compassion and kindness as part of the health care role.

Contextual factors affecting sensitivity to staff attitudes, behaviour and communication

In the letters, descriptions of unsatisfactory healthcare encounters were often set within the context of factors which patients and their carers believed influenced their perceptions of the care they received from healthcare professionals, although this may not have been disclosed at the time. These included patient and carers' expectations of the healthcare encounter, often because of preconceived ideas about the diagnosis and treatment they would receive, and personal circumstances which they believed to have resulted in increased stress and sensitivity to perceived poor communication and staff attitudes and behaviour. These data illustrate the level of communication skill required for healthcare staff to be perceived as caring in circumstances where, for reasons they may not be aware of, patients or relatives do not feel able to respond in a positive way. This was particularly the case in departments which complainants highlighted as dealing with particularly sick or stressed patients, such as cancer services or as described here, the accident and emergency department:

"In a place like A&E, I would expect staff to be trained to be sensitive to the situation of both patients and members of the public who find themselves in a very stressed situation of their loved ones being in A&E." (Scott)

Understandably, many patients were facing serious and in some cases life-limiting health problems. One patient who had been recently diagnosed as terminally ill proposed that her negative feelings were to be expected:

"I think it was natural for me to feel anxious and depressed." (Fernando)

And another patient put her very difficult situation equally succinctly:

"Three days later I was told I had 5 to 18 months to live so all in all it was not a very good week for me." (Imrie)

One patient who was undergoing rehabilitation following a stroke described the context of her complaint about the communication skills of the consultant responsible for her care in a stroke rehabilitation ward:

"I was toiling away at physiotherapy for several hours a day precisely to learn to walk again, finding it painful, tiring and incredibly difficult to put one leg in front of the other." (Drever)

Although undisclosed, the feelings of these patients could probably be anticipated, but complainants also referred to factors which may have been less easy to anticipate. For example, one complainant who suffered from mental health problems referred to her feelings of claustrophobia, in a complaint about care when her child was an inpatient:

"I can't handle enclosed spaces with people, especially when under extreme stress. The hospital is a labyrinthine rabbit warren, the signage sparse and unhelpful." (Lawrence)

It was not only background issues concerning health which were highlighted by complainants. The stresses of travel also contributed. A father described how a rude member of staff marred what should have been a happy family occasion for his parents, who had driven from northern Scotland in blizzard conditions to see their first granddaughter:

"My parents were about to meet their first granddaughter which should be one of the happiest moments of anybody's life, but it was unnecessarily spoiled by the rudeness and unprofessionalism of this member of staff." (Eastwood)

Some patients' complaints about staff attitudes, behaviour and communication were set against a background of their expectations of the healthcare encounter being disappointed. For

example one patient was referred for an endoscopy as he had been suffering from severe heartburn for three months, causing serious discomfort. When he arrived at hospital he was refused the test, and told the problem was caused by his weight. Another patient had been advised by her general practitioner that she probably had a hernia, but was diagnosed as having a condition that was benign but not amenable to surgery. Her description of a consultant's brusque and unsympathetic manner was set against her disappointment that nothing could be done to reduce a disfiguring condition.

Both these patients were particularly critical about the way in which they were informed that their expectations were not going to be met. They appeared to be more sensitive to the way information was communicated and the attitudes of staff they encountered than might perhaps have been the case if the outcome of the appointment had been in line with their expectations.

One of the complaints about all staff in a department was set against a background of both difficulty in getting to the appointment and disappointment that the therapist the patient expected to see had retired.

Failure to meet expected norms of communication in a formal encounter

Some complainants thought that the staff involved had failed to meet the standards expected of a formal social encounter. This included failure to introduce themselves, rushing the encounter, flippancy and failure to maintain communication on a polite and formal level.

One of the difficulties related to the fact that staff did not always introduce themselves and also that in some cases patients and their families did not know the role of staff, for example whether a member of staff was a qualified nurse or a health care assistant.

Patients referred to staff they encountered who *"could have been someone off the street"* (Galloway) and whom they *"presumed to be a nurse."* (Trotter)

Eye contact is also expected and a complainant who was particularly anxious about having surgery, described how someone she presumed was an anaesthetist, came into the anaesthetic room and started to talk to her without introducing himself and standing where she could not see him.

This highlights the need for staff to remember that, whilst they are in a familiar environment and may not see every patient contact as a formal encounter, patients and their families are generally in a very strange environment and that a few words of introduction and explanation can alleviate the stress of not knowing staff names and roles.

Many of the complainants described feeling rushed during health care encounters. Some descriptions included:

"I felt he rushed the examination and did not take the time to explain his findings which left me feeling as if I was rushed in and out as quick as possible." (Christie)

"He did not give me any chance to put any of my points across or ask questions." (Henry)

This resulted in patients not understanding what they were being told and also precluded any discussion or an opportunity to present their own views or ask questions.

In other examples where the patient felt rushed and dismissed, the staff member had used informal language and failed to retain a more formal, polite approach. For example, a patient phoning for an appointment reported that:

"With an abrupt tone I was told not to be so stupid, not at this short notice." (Crockett)

An informal approach in itself was unacceptable for some people. For example, one consultant referred to a side room as *"the best room in the hotel"* (Drever). Referring to orthotics he commented:

"You are very lucky to have these. Do you know how much these cost?" (Drever)

When another complainant tried to explain to a consultant what staff and A&E had told him, “*he dismissed me and said it was ‘rubbish’.*” (Fernando)

These examples highlight the need to avoid what in another situation might be construed as informality and mild humour, but in the healthcare setting may be interpreted as cruel facetiousness.

In other complaints it was the tone rather than the content of the communication which caused offence. Words commonly used by complainants to describe poor care included “rude”, “arrogant”, “abrasive” and “abrupt.” Some complainants also described the body language which exacerbated the effects of sharp tones and cruel words. These included: “scowled” (Eastwood) and “She sighed heavily” (McKenzie).

For another complainant, the situation was exacerbated because the consultant spoke to the patient during an examination:

“It was not just what he said, but how he said it, in an arrogant and dismissive tone, when I was in an extremely vulnerable position, unable to see him and he was in a position of power.” (Watson)

In a small number of complaints, complainants suggested that staff had deliberately set out to cause distress. One complainant felt that a nurse:

“verbally attacked me.... really trying to upset me.” (Galloway)

Another believed:

“that the waiting list manager had phoned simply to verbally punish me for cancelling the appointment.” (McKenzie)

Effects of poor staff attitudes, behaviour and communication on recipients

While the effects of poor staff attitudes, behaviours and communication are implicit throughout the paper, this section makes these effects explicit. Complainants explained how poor staff

attitudes, behaviour and communication impacted on their feelings, on clinical outcomes and on future healthcare encounters.

Effects on patients' feelings

Most complainants highlighted the effects of poor staff attitudes, behaviour and communication on their feelings, particularly within the context of other issues discussed earlier such as the stresses they were experiencing and their expectation that health care staff would be kind and compassionate.

Complainants described their feelings as “angry”, “dejected”, “anxious” “shocked” “humiliated and degraded.” Some described being very distressed:

“I left the consulting room in tears.” (Ritchie)

“I was most upset about not having any answers and by the way I had been treated.” (Christie)

Some complainants were quite explicit about blaming staff for the way they felt:

“I was made to feel like an inconvenience.” (Laidlaw)

These negative emotional responses to poor staff behaviour, attitudes and communication demonstrate the impact of poor attitudes, behaviours and communication.

Effects on clinical outcome

As well causing distress to patients, complainants were concerned about the longterm effect of poor staff attitudes and behaviour on patients' health.

One complainant said:

“I was no better informed on how to manage my condition than I was before I went to the appointment.” (Anderson)

Another patient, who was having rehabilitation and was therefore being seen by a doctor

frequently over a long period was concerned that the outcome of her rehabilitation was being compromised by the doctor's attitude:

"I do not care about the doctor's bizarre manner, but doubt if he is capable of being objective about me. He has never moved my progress forward." (Drever)

Effects on future healthcare encounters

When patients had encountered staff with poor attitudes and behaviour, indicating a lack of compassion and kindness, they were worried about future healthcare encounters.

One patient was reluctant to attend for a routine 20 week scan during pregnancy *"as it fills me with dread"* (Everitt). Others made similar comments such as:

"I am scared to contact the hospital." (Stevenson)

In some cases, patients had decided not to go to hospital when it would have been prudent to do as one complainant described:

"On several occasions afterwards I did not go to hospital at night when I should have because I did not want to face another lecture or be made to feel like an outcast." (Laidlaw)

Parents withdrew one child from having speech therapy sessions because they felt that the negative effect the therapist's attitude towards the child was having outweighed the benefits he might derive from the therapy itself.

The three complaints about all staff in a department were made by carers of patients with complex psychosocial and emotional needs: an elderly patient with dementia, an adult with learning disabilities and a teenager with autism who all felt that in general, all staff caring for these patients did not demonstrate appropriate attitudes, behaviours and communication.

DISCUSSION

The analysis demonstrates the context and sequelae of perceived poor attitudes and behaviours of healthcare staff in terms of patients' emotional wellbeing and their likelihood to seek healthcare in the future. The contextual information included in the complaints highlights the stress which patients may be experiencing, and the heightened sensitivities that this engenders. Patients' perceptions of staff attitudes and behaviours also appear to be affected by their expectations of a healthcare encounter including the assumption that healthcare staff are naturally compassionate, empathic and kindly, the diagnosis and treatment the patient expects and sometimes the individual they expect to see.

The strength of language used by complainants suggests that the impact of negative encounters is significant. Staff attitudes and behaviours affect patient outcomes in terms of their feelings and their confidence in the outcomes of current and future healthcare encounters (Figure 1).

The findings of the study demonstrate the need for all healthcare staff to understand the impact of their attitudes, behaviours and style of communication on patients.

Although the letters of complaint were written some time ago, they largely refer to lapses in individual communication practice rather institutional communication practices which may have changed over the intervening period. Also, although only the letter of complaint itself has been analysed and thus only the viewpoint of the complainant has been considered, the content analysis of these letters of complaints has value in illuminating the both the external and internal factors which prompt people to complain about communication, attitudes and behaviour. Even without the perspectives of the staff about whom the complaints have been made and the contextual factors of significance to them being available, the analysis points to exceptional levels of skill in communication being expected to meet the needs of people who may be feeling stressed and disappointed for reasons which are sometimes obvious but at other times totally unexpected. Odelius et al (2015) and Allan et al (2015) used action research to explore the management of patient complaints and how to support staff to effectively manage

and respond appropriately to them. They found that the complaint process is complex and complicated and a deeply emotional experience for both service users and staff (Allan et al 2015).

A range of health care staff were the subject of the complaints, but the sample size did not allow for comparison between different groups of staff. This could usefully be explored in future research, as it is not clear whether the same level of skills are expected from professionally qualified and support staff. Preparing staff to meet these expectations is a challenge. While training courses aimed at promoting good attitudes, behaviour and communication among health care staff can be effective, particularly if supported by supervisory support and self-generated feedback where the individual observes and critiques their own performance behaviour and communication, they are often disconnected from the workplace on both a practical and managerial level (Heaven et al. 2005), and communications training is rarely underpinned by an explicit theoretical framework (Ong et al 1995, McCluskey et al 2011).

Mann (2005) proposes emotional labour as the basis of a health care model to implement patient – centred emotional skills training by inviting recovered patients to attend training sessions for staff to share their perspectives on emotional aspects of care which mattered to them in various clinical areas. Studies of student nurse learning (Smith 1992, 2012), have shown the power of the concept of emotional labour to provide a language to understand the meaning of both giving and learning to care in the way the complainants in our study considered necessary. We also consider the association between emotional intelligence (Mayer and Salovey 1993) and emotional labour (Huy 2000) illustrated by examples from the literature.

Emotional labour, is defined by Hochschild (1983) as “the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place”. Emotional labour is often seen as an invisible and natural aspect of caring professions traditionally undertaken by women (Gray and Smith 2009). Hochschild (1983)

describes two levels of emotional labour: surface acting involves regulating only the behaviour without feelings about the situation while deep acting involves trying to feel the emotion that is required in order to instigate the behaviour required, either because of an inherent wish to change behaviour or because it is expected. Thus the required and genuinely felt emotions are the same. It has been shown that among nurses surface acting is positively linked with burnout (emotional exhaustion) and negatively linked to job satisfaction, while deep acting has a weaker relationship to burnout and no effect on job satisfaction (Diefendorff et al. 2011, Chou et al. 2012).

In some occupations, such as the flight attendants in Hochschild's ground breaking study, emotional labour is used for a relatively short and well-defined time period in order to contain emotions and make the experience as pleasant and safe as possible for staff and those for whom they are caring. The only longer term goal of flight attendants is to encourage passengers to use the same airline for future travel. In healthcare settings there is a large range in terms of the level of emotional labour required to provide good care (Smith 2012). For some groups of workers, such as receptionists, who have short and superficial encounters with patients, but nonetheless have a vital role in "oiling the wheels" in the service (Davis and Rosser 1986), scripts promoting appropriate surface acting may be pertinent. Other groups of health care workers, such as nurses, subscribe to professional feeling rules which entail always appearing warm and sympathetic and at the same time composed and objective, but also to move beyond these rules and at their own discretion choose to add something extra to the patient/carer relationship (Bolton 2000). Having insights into the different types of emotional labour required in different situations is likely to be useful for health care professionals. According to Huy (2000) emotional labour is also required for the development and use of emotional intelligence. Analysis of the data reported here suggests that the attitudes, behaviours and communication styles required by health care staff depend on emotional intelligence in order to be able to deal with their own emotions and those of patients and colleagues.

Emotional intelligence is defined as assessing, demonstrating and controlling emotions and using these skills to modify the emotional states, such as anxiety, being experienced by oneself and others (Mayer and Salovey, 1993). Stenhouse et al's (2016) reflective paper presents the debates surrounding the theoretical connections between emotions and compassion while Snowden et al (2016) recommend caution in attributing a direct correlation between emotional intelligence and the individual practitioner's ability to give sensitive care when external factors are likely to be involved. Emotional intelligence is seen to focus primarily on personality traits and attributes whereas emotional labour considers the influence of contextual, environmental, organisational and societal factors.

Freshwater and Stickley (2004) suggest the emotionally intelligent practitioner "hears the sigh, makes eye contact, communicates understanding and demonstrates human care" (p93). These qualities they argue can only be achieved through educational curricula underpinned by a critical appreciation of the role of emotional intelligence in 'transformational learning' and an educational strategy based on reflection, mentorship, self-enquiry, storytelling and service user involvement. Msiska et al (2014a, 2014b) also draw on emotional labour to show how even in resource poor environments nursing students in Malawi were able to learn during their three year programme how to undertake emotional labour to protect themselves from burnout and enable them to care compassionately for severely ill patients.

As illustrated above there is thus a strong supporting literature for the applicability of emotional labour and emotional intelligence as conceptual tools for providing appropriate organisational and educational support to enable healthcare professionals to give sensitive care. Further research is required in this area.

Since these letters of complaint were written, there have been some changes to the way in which patient feedback is managed both UK wide and in Scotland. From 2011 the website Patient Opinion (<https://www.patientopinion.org.uk>) has been promoted as a platform for patients in Scotland and elsewhere in the United Kingdom (UK) to provide feedback about their

experiences of healthcare, with the Scottish Government endorsing its use in 2013. The Patient Rights Scotland Act (Scottish Government 2011) sets out a charter for patients rights which include compassionate care and good communication, with clear mechanisms for encouraging and responding to feedback from patients and their carers. It also sets out the requirement for patients and their carers to have access to a designated resource from outside the health service to provide support in preparing complaints and engaging with the health service. This is currently provided by a dedicated service at Citizens Advice Scotland, a third sector organisation providing advice on a range of issues including benefits, housing and consumer rights. The findings reported in this paper are therefore very relevant to the current emphasis on encouraging and valuing feedback about experiences of healthcare to improve the quality of the service.

Conclusions

In view of the increasing focus on patient experience, it is important that health care staff, managers and professional leaders understand the high level of communication skill expected of them by the public. This includes being able to convey compassionate and caring attitudes in situations where, for obvious or hidden reasons, individuals may not be responding as expected. The twin concepts of emotional labour and emotional intelligence may be helpful in underpinning training and supporting staff to adopt effective behaviours, attitudes and communication. Understanding the different levels at which they operate may enable administrative staff, healthcare professionals to develop mechanisms for dealing with their emotions and with situations they find challenging. This will help to facilitate positive behaviour, attitudes and communication through compassion and kindness and put these aspects of care on the same footing as more technical aspects of care supported by health professional leaders committed to creating a caring culture.

Relevance to clinical practice

Given the important role of communication, behaviour and emotion in providing sensitive and appropriate care to patients and clients, it is important that this aspect of care is recognised and discussed and, rather than remaining invisible, considered to be an inherent part of the role. Efforts need to be made to minimise the negative effects and ensure that it results in positive outcomes for patients and health care workers. Within a framework of emotional labour and emotional intelligence health care professionals and their professional leaders could be encouraged to consider how these fit with their specific area of practice, from working with families with child protection issues to the fast paced environment of emergency care or the care of elderly people in nursing homes. The recognition of the protective effects on staff wellbeing of understanding patients' perspectives rather than resorting to surface acting are also important in preventing burnout among staff, especially those working in particularly stressful environments. Education and skills training are essential to support health care professionals and students to give care that is both compassionate and kind while enabling them to care for themselves and each other.

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Table 1: Focus of complaints – Clinical Area and Staff Groups

Pseudonym	Clinical Area	Staff Groups
Anderson	Physiotherapy	Physiotherapist
Booth	Out Patient Clinic	Clerical
Buchanan	Neurology	Doctor
Cameron	Medicine	Doctor
Christie	Out Patient Clinic	Consultant
Cochrane	Endoscopy	Clerical
Cooper	Out Patient clinic	Doctor
Crocket	SMART	Receptionist
Dickson	Endoscopy	Consultant
Donaldson	Paediatric	Medical staff
Drever	Post stroke Rehabilitation	Consultant
Duncan	Out Patient Clinic	Clerical
Eastwood	Maternity	Health care assistant
Everitt	Maternity	Sonographer
Ferguson	Mental health	Nurses
Fernando	Out Patient Clinic	Doctor
Fraser	Out Patient Clinic	Receptionist
Galloway	Accident and Emergency	Nurse
Goodall	Ear, Nose and Throat Ward	Doctor
Henry	Out Patient Clinic	Consultant
Hogarth	Speech Therapy	Speech therapist
Hopkins	Maternity	Sonographer
Horsburgh	Out Patient Clinic	Consultant
Illingworth	Medical ward	All staff groups
Imrie	Medical ward	Nurse
Jeffrey	CAMHS	Nurse
Jolliffe	Endoscopy	Doctor
Kennedy	Maternity	Midwives
Kernohan	Community Child Health	Whole department
Laidlaw	Maternity	Doctor and midwife
Laing	Care of elderly ward	Doctor
Lawrence	Paediatric ward	Nurses
Leadbetter	Accident and Emergency	All staff
McCormack	Maternity	Sonographer
McIntyre	Podiatry	Podiatrist
McKenzie	Endoscopy	W/L manager
McQuarrie	Community midwifery	Midwife
Menzies	GP surgery	Receptionist
Merrylees	Mental health ward	Nurse
Mitchell	Surgery	Doctor
Norman	Out Patient Clinic	Consultant
Oswald	Medical ward	Nurse
Reid	Rheumatology and surgical	Doctors
Ritchie	Out Patient Clinic	Consultant
Scott	Accident and Emergency	Receptionist
Simpson	HDU	Nurse
Stevenson	Maternity	Midwife

Watson	Eye ward	Consultant
Weatherly	Out Patient Clinic	Clerical
Wilson	A&E	All staff

Figure 1: Factors affecting patient and carer satisfaction with healthcare

